Motor Vehicle Administration
6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

DC-088 (08-10)

Consent for the Release of Confidential Information

PLEASE FURNISH COMPLETE NAMES AND ADDRESSES BELOW

DRIVER WELLNESS & SAFETY DIVISION
MEDICAL REVIEW SECTION
(410) 768-7511

DC-5

NOTICE DATE _____

SOUNDEX NUMBER _____

This Administration is in receipt of information which indicates that you may have a physical, mental, or chemical dependency problem which might affect your ability to safely operate a motor vehicle. We are requesting that you furnish to the Motor Vehicle Administration (MVA) the names of all doctors, hospitals, alcohol and drug clinics, and other programs where you have received treatment or have been monitored and that you execute this authorization for release of medical records and data pertaining to the same.

The purpose for this authorization is to enable the Motor Vehicle Administration to obtain relevant medical data pertaining to its evaluation of your ability to safely operate a motor vehicle. All medical data obtained under this authorization will be kept CONFIDENTIAL and will only be used for those purposes set out in Section 16-118 of the Transportation Article of the Annotated Code of Maryland.

This authorization is to be completed and returned by _____

RELEASE FOR MEDICAL INFORMATION

By execution of this authorization, _____ gives permission to

PRINTED NAME (Primary Care/Family Practice/Internist)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER
PRINTED NAME (Other treatment facility or program)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER
PRINTED NAME (Other treatment facility or program)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER
PRINTED NAME (Other treatment facitlity or program)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER

to release to the Motor Vehicle Administration all information relative to treatment for a physical, mental, or chemical dependency problem (attendance, treatment, participation, prognosis, rehabilitation).
This authorization will expire on _____.

This authorization may be withdrawn any time except to the extent that information has already been released in reliance thereon.

Signed: _____ Date: _____

Social Security Number: _____ Telephone Number: _____

If you are a minor, your parent or legal guardian must sign as a witness. Witness: _____

NOTE: The above named individual, not MVA, is responsible for any cost incurred as a result of requests made for medical information.

If you have any questions, please contact the Medical Review Section at the above-listed address.

PROHIBITION OF REDISCLOSURE: THIS ADMINISTRATION IS PROHIBITED FROM MAKING ANY FURTHER DISCLOSURES OF INFORMATION FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY THE MARYLAND MOTOR VEHICLE LAW GOVERNING MEDICAL ADVISORY BOARD CASES AND BY FEDERAL LAW, EXCEPT WITH SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY FEDERAL REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.